16463 Boones Ferry Suite 100 · Lake Oswego, OR 97035
(503) 635-1350 Fax: (503) 635-8470

# RELEASE OF INFORMATION CONSENT

I understand that Lake Grove Family Medical Clinic maintains records of my medical and billing information as part of my healthcare. Under the requirements of HIPAA, this information is not to be given to any other person without my permission.

By signing this consent, I authorize Lake Grove Family Medical Clinic to release my medical and/or billing information to the following individual(s).

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |

By **initialing** the spaces below, I specifically authorize the release of the following medical information, if such exists.

________Mental Health ________Worker's Compensation ________Alcohol Dependency

________HIV / STD ________Motor Vehicle ________Chemical Dependency

☐ **I decline to have my medical and/or billing information discussed with family or friends.**

**I understand I have the right to revoke this authorization at any time.**

______________________________________________
Printed Name of the Patient

______________________________________________ ____________________
Signature of the Patient or Responsible Party Date